National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832, Chantilly, Virginia 20153-0832 • www.npdb-hipdb.hrsa.gov

Draft Medical Malpractice Payment Report

This form is for your convenience in drafting Medical Malpractice Payment Reports for ultimate submission to the NPDB. **Do not mail this form to the Data Banks.** Medical Malpractice Payment Reports must be submitted to the National Practitioner Data Bank (NPDB) using the Integrated Querying and Reporting Service (IQRS), the Querying and Reporting XML Service (QRXS), or the Interface Control Document (ICD) Transfer Program (ITP), which are available at *www.npdb-hipdb.hrsa.gov*.

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission. If spaces are provided for multiple responses to an item, you only need to complete as many of the responses as you have information for. There is no need to repeat responses or enter "Not Applicable," etc.

OMB # 0915-0126 expiration date 05/31/07

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Subject Name

Last Name	First Name	Middle Name	Suffix
(25 characters)	*(15 characters)*	*(15 characters)*	*(4 characters)*

Other Names Used

	Last Name	First Name	Middle Name	Suffix
	(25 characters)	*(15 characters)*	*(15 characters)*	*(4 characters)*
1.				
2.				
3.				
4.				
5.				

Gender: ☐ Male ☐ Female ☐ Unknown

Birth Date (MMDDYYYY)**:**

Work Organization Name *(50 characters)***:**

Work Address

(See Lists A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Home Address/Address of Record

(See List A-1 and A-2 for information on filling out non-U.S. and military addresses)

Street Address *(40 characters)*:
Address Line 2 *(40 characters)*:
City *(28 characters)*:
State (Choose State code from List A-1):
ZIP Code: -
Country (If U.S., leave blank; *20 characters*):

Is Subject Deceased?

☐ No
☐ Unknown
☐ Yes – Deceased Date (MMDDYYYY):

Social Security Numbers (SSN) (Format NNNNNNNNN)

1. **2.**
3. **4.**

Drug Enforcement Administration (DEA) Numbers *(12 characters)*

1. **2.**
3. **4.**

Professional Schools Attended (Name, City, State/Country; *40 characters*)

Year of Graduation (Format YYYY)

1.
2.
3.
4.
5.

Occupation and State Licensure Information
(If no State License, check the 'No License' box)

1. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

2. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

3. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

4. **State License Number** *(16 characters)*: **OR** ☐ No License
State of Licensure (Choose State code from List A-1):
Occupation/Field of Licensure (Choose one three-digit code from List B):
Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

5. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

6. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

7. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

8. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

9. **State License Number** *(16 characters)*: **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*):

10. State License Number *(16 characters)***:** **OR** ☐ No License

State of Licensure (Choose State code from List A-1):

Occupation/Field of Licensure (Choose one three-digit code from List B):

Description (Only complete for Occupation/Field of Licensure Code 699; *60 characters*)**:**

Hospital Affiliation(s) *(40 characters)*	**City** *(28 characters)*	**State** (Choose State code from List A-1)
1.		
2.		
3.		
4.		
5.		

Payment Information

Relationship of Entity to This Practitioner (Choose one from list):

Note: A health insurance company, managed care organization, or health care entity (such as a hospital, health plan, group practice, government agency and department that provides health care services) that makes a payment for a practitioner on its own staff because the company pays its own malpractice claims rather than having coverage for malpractice claims under an insurance policy issued by another company should report as a Self-Insured Organization. A State fund should select the code "State Medical Malpractice Payment Fund as the Primary Payer for the Practitioner" if the fund is the payer of first resort for a claim and select the code "State Medical Malpractice Payment Fund as a Secondary Payer for the Practitioner" if the fund is the payer for any amount in excess of the primary amount.

☐ Insurance Company – Primary Insurer
☐ Insurance Company – Excess Insurer
☐ Self-Insured Organization
☐ Insurance Guaranty Fund
☐ State Medical Malpractice Payment Fund as the Primary Payer for This Practitioner
☐ State Medical Malpractice Payment Fund as a Secondary Payer for This Practitioner

Payments by This Payer for This Practitioner

If you made a single payment for multiple practitioners and if the settlement agreement or judgment does not specify an amount for each practitioner, you must allocate the total payment between the practitioners and specify an amount greater than zero for this practitioner. If a settlement agreement specifically states that no payment was made for this practitioner, do not file this report. The total amount paid or to be paid by you for all practitioners must be specified in the appropriate field. You must file a separate report for each practitioner named in the claim and judgment or settlement unless the judgment or settlement specifically states that no payment was made for that practitioner.

Amount of This Payment for This Practitioner
(Format NNNNNNNNN.NN): $

Date of This Payment (MMDDYYYY):

Select the payment type (i.e., Single or Multiple) to indicate whether the payment specified in the Amount of This Payment field is a single final payment or is one of multiple payments to be paid in series. Only the first payment of a series of payments must be reported, except when a preliminary payment is made before a final settlement is reached.

If this payment represents a preliminary payment prior to settlement:

1. Select One of Multiple Payments in this field; enter the preliminary payment amount in both the Amount of This Payment for This Practitioner and the Total Amount Paid or to be Paid by This Payer for This Practitioner fields; and
2. Explain the circumstances of the preliminary payment in the Description of the Judgment or Settlement field.
3. Once the settlement is reached, file a Correction Report and provide the revised total amount of all payments in the Total Amount Paid or to be Paid by This Payer for This Practitioner field.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. In these cases:

1. Report the amount of the first payment in the Amount of This Payment for This Practitioner field.
2. Complete the Total Amount Paid or to be Paid by This Payer for This Practitioner field, consistent with the instructions below.

This Payment Represents: ☐ A Single Final Payment ☐ One of Multiple Payments

If this report concerns a preliminary payment before a final settlement is reached and the total amount ultimately to be paid is unknown:

1. Enter only the amount of this payment; and
2. Explain in the Description of the Judgment or Settlement field;
3. Then, file a Correction Report once the settlement is reached and the total amount is known.

If this payment represents a payment made after a final settlement, only the first payment of a series of payments must be reported. If this payment is part of a structured settlement, report the cost of purchasing the structured settlement arrangement or the present value of the total payments to be made over the lifetime of the obligation if a structured settlement arrangement is not purchased.

Total Amount Paid or to Be Paid by This Payer for This Practitioner
(Format NNNNNNNNN.NN): $

Payment Result of: ☐ Judgment ☐ Settlement ☐ Payment Prior to Settlement

Date of Judgment or Settlement, if Any (MMDDYYYY):

Adjudicative Body Case Number (if Applicable; *20 characters*):

Adjudicative Body Name (if Applicable; *60 characters*):

Court File Number (if Applicable; *10 characters*):

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment
(Limit 2,000 characters including spaces and punctuation)

Note: Do not reference any personal identification information (e.g. names) of anyone other than the subject of this report.

Payments by This Payer for Other Practitioners in This Case

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case (Including the Amount Specified Above for This Practitioner; Format NNNNNNNNN.NN): $

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization.

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?

☐ Yes
☐ No
☐ Unknown

Amount Paid or Expected to Be Paid by the State Fund (Format NNNNNNNNN.NN): $

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund.

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?
☐ Yes
☐ No
☐ Unknown

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies (Format NNNNNNNNN.NN): $

Classification of Act(s) or Omissions

Patient's Age at Time of Initial Event (enter 0 days if the patient is a fetus):
☐ Days (if less than 1 month)
☐ Months (if less than 1 year)
☐ Years
☐ Unknown

Patient's Gender: ☐ Male ☐ Female ☐ Unknown

Patient Type: ☐ Inpatient ☐ Outpatient ☐ Both ☐ Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)

Enter a narrative description of the actual diagnosis with which the patient presented for treatment. Do not report a misdiagnosis. If the patient had more than one condition, enter the condition most applicable to the alleged acts or omissions. *(Limit 1,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g. names) of anyone other than the subject of this report.

Description of the Procedure Performed

Enter a narrative description of the treatment rendered by the insured to the patient for the initial medical condition specified in this report. If more than one procedure was performed by the insured, report the one that is most significant to the claims generation. *(Limit 1,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g. names) of anyone other than the subject of this report.

Nature of Allegation (choose one from list)**:**

- ☐ Anesthesia Related
- ☐ Behavioral Health Related
- ☐ Diagnosis Related
- ☐ Equipment/Product Related
- ☐ IV & Blood Products Related
- ☐ Medication Related
- ☐ Monitoring Related
- ☐ Obstetrics Related
- ☐ Surgery Related
- ☐ Treatment Related
- ☐ Other Miscellaneous

Specific Allegation (Select the most significant allegation first.)

Note: Only select the same code for both allegations if the alleged act or omission occurred more than once and on different dates.

1. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

2. **Specific Allegation** (Choose one three-digit code from List C):

   Description (Only complete for Specific Allegation Code 999; *60 characters*)*:*

   Date of Event Associated With Allegation or Incident (MMDDYYYY):

Outcome (Choose one from list)**:**

- ☐ Emotional injury only
- ☐ Insignificant injury
- ☐ Minor temporary injury
- ☐ Major temporary injury
- ☐ Minor permanent injury
- ☐ Major permanent injury
- ☐ Significant permanent injury
- ☐ Quadriplegic, brain damage, lifelong care
- ☐ Death
- ☐ Cannot be determined from available records

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

Reporting entities must use this field to summarize the allegations of the plaintiff or claimant in demanding payment even if the reporting entity believes these allegations to be without merit. Reporters may also use this section to summarize important issues in the case and to provide, as needed, additional information not reported in the Classification of Acts or Omissions section of this report. *(Limit 2,000 characters including spaces and punctuation)*

Note: Do not reference any personal identification information (e.g. names) of anyone other than the subject of this report.

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Banks, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference (e.g., claim number; *20 characters*):

List A-1
State Abbreviations and U.S. Territories

AL	Alabama	KY	Kentucky	ND	North Dakota
AK	Alaska	LA	Louisiana	OH	Ohio
AZ	Arizona	ME	Maine	OK	Oklahoma
AR	Arkansas	MD	Maryland	OR	Oregon
CA	California	MA	Massachusetts	PA	Pennsylvania
CO	Colorado	MI	Michigan	RI	Rhode Island
CT	Connecticut	MN	Minnesota	SC	South Carolina
DE	Delaware	MS	Mississippi	SD	South Dakota
DC	District of Columbia	MO	Missouri	TN	Tennessee
FL	Florida	MT	Montana	TX	Texas
GA	Georgia	NE	Nebraska	UT	Utah
HI	Hawaii	NV	Nevada	VT	Vermont
ID	Idaho	NH	New Hampshire	VA	Virginia
IL	Illinois	NJ	New Jersey	WA	Washington
IN	Indiana	NM	New Mexico	WV	West Virginia
IA	Iowa	NY	New York	WI	Wisconsin
KS	Kansas	NC	North Carolina	WY	Wyoming
AS	American Samoa	GU	Guam	PR	Puerto Rico
FM	Federated States of Micronesia	MP	Northern Marianas	VI	Virgin Islands
		PW	Palau		
AA	Central and South America (Armed Forces)	AE	Europe (Armed Forces)	AP	Pacific (Armed Forces)

Please adhere to the following guidelines when entering foreign or military addresses:

Addresses for United States Territories:
- Enter Territory abbreviation in "State" field.

Addresses outside the United States or its territories:
- Leave the "State" field blank.
- Enter the city and/or province in the "City" field.
- Enter the Country Code in the "ZIP" fields - maximum 5 characters in first field, maximum 4 characters in the second field.
- Enter the country in the "Country" field.

Military Addresses:
- Enter APO or FPO in the "City" field.
- Enter AE, AA, or AP in the "State" field.
- Enter the ZIP code in the "ZIP" field.

Following State Codes are not valid for State of Licensure:
- AA Central and South America (Armed Forces)
- AE Europe (Armed Forces)
- AP Pacific (Armed Forces)

List A-2
APO/FPO Postal Codes*

APO/FPO Code	First 3 digits of ZIP Code	Geographic Area	APO/FPO Code	First 3 digits of ZIP Code	Geographic Area
AE - Europe	090-092	Germany	**AA – Americas**	340	Central, South Americas
	094	United Kingdom			
	095	Atlantic Ocean/ Mediterranean Sea Ships	**AP – Pacific**	962	Korea
				963	Japan
	096	Italy, Spain		964	Philippines
	097	Other Europe		965	Other Pacific and Alaska
	098	Middle East, Africa		966	Pacific and Indian Ocean Ships

* APO/FPO Codes (State Codes) are not valid for State of Licensure. Refer to List A-1.

List B
Occupation/Field of Licensure Codes

603 Chiropractor

Counselor
621 Counselor, Mental Health
651 Professional Counselor
654 Professional Counselor, Alcohol
657 Professional Counselor, Family/Marriage
660 Professional Counselor, Substance Abuse
661 Marriage and Family Therapist

Dental Service Provider
030 Dentist
035 Dental Resident
606 Dental Assistant
609 Dental Hygienist
612 Denturist

Dietician/Nutritionist
200 Dietician
210 Nutritionist

Emergency Medical Technician (EMT)
250 EMT, Basic
260 EMT, Cardiac/Critical Care
270 EMT, Intermediate
280 EMT, Paramedic

Eye and Vision Service Provider
630 Ocularist
633 Optician
636 Optometrist

Nurse/Advanced Practice Registered Nurse
100 Registered (Professional) Nurse
110 Nurse Anesthetist
120 Nurse Midwife
130 Nurse Practitioner
140 Licensed Practical or Vocational Nurse
141 Clinical Nurse Specialist

Nurse Aide, Home Health Aide and Other Aide
148 Certified Nurse Aide/Certified Nursing Assistant
150 Nurses Aide
160 Home Health Aide (Homemaker)
165 Health Care Aide/Direct Care Worker
175 Certified or Qualified Medication Aide

Pharmacy Service Provider
050 Pharmacist
055 Pharmacy Intern
060 Pharmacist, Nuclear
070 Pharmacy Assistant
075 Pharmacy Technician

Physician
010 Physician (MD)
015 Physician Intern/Resident (MD)
020 Osteopathic Physician (DO)
025 Osteopathic Physician Intern/Resident (DO)

Physician Assistant
642 Physician Assistant, Allopathic
645 Physician Assistant, Osteopathic

Podiatric Service Provider
350 Podiatrist
648 Podiatric Assistant

Psychologist/Psychological Assistant
371 Psychologist
372 School Psychologist
373 Psychological Assistant, Associate, Examiner

Rehabilitative, Respiratory and Restorative Service Provider
402 Art/Recreation Therapist
405 Massage Therapist
410 Occupational Therapist
420 Occupational Therapy Assistant
430 Physical Therapist
440 Physical Therapy Assistant
450 Rehabilitation Therapist
663 Respiratory Therapist
666 Respiratory Therapy Technician

300 Social Worker

Speech, Language and Hearing Service Provider
400 Audiologist
460 Speech/Language Pathologist
470 Hearing Aid/Hearing Instrument Specialist

Technologist
500 Medical Technologist
505 Cytotechnologist
510 Nuclear Medicine Technologist
520 Radiation Therapy Technologist
530 Radiologic Technologist

Other Health Care Practitioner
600 Acupuncturist
601 Athletic Trainer
615 Homeopath
618 Medical Assistant
624 Midwife, Lay (Non-Nurse)
627 Naturopath
639 Orthotics/Prosthetics Fitter
647 Perfusionist
170 Psychiatric Technician
699 Other Health Care Practitioner - Not Classified, Specify,
_____

List C
Specific Allegation Codes*

Failure to Take Appropriate Action
100 Failure to Use Aseptic Technique
101 Failure to Diagnose (i.e., Concluding That Patient Has No Disease or Condition Worthy of Follow-Up or Observation)
102 Failure to Delay a Case When Indicated
103 Failure to Identify Fetal Distress
104 Failure to Treat Fetal Distress
105 Failure to Medicate
106 Failure to Monitor
107 Failure to Order Appropriate Medication
108 Failure to Order Appropriate Test
109 Failure to Perform Preoperative Evaluation
110 Failure to Perform Procedure
111 Failure to Perform Resuscitation
112 Failure to Recognize a Complication
113 Failure to Treat

Delay In Performance
200 Delay in Diagnosis
201 Delay in Performance
202 Delay in Treatment
203 Delay in Treatment of Identified Fetal Distress

Error/Improper Performance
300 Administration of Blood or Fluids Problem
301 Agent Use or Selection Error
302 Complementary or Alternative Medication Problem
303 Equipment Utilization Problem
304 Improper Choice of Delivery Method
305 Improper Management
306 Improper Performance
307 Improperly Performed C-Section
308 Improperly Performed Vaginal Delivery
309 Improperly Performed Resuscitation
310 Improperly Performed Test
311 Improper Technique
312 Intubation Problem
313 Laboratory Error
314 Pathology Error
315 Medication Administered via Wrong Route
316 Patient History, Exam, or Workup Problem
317 Problems With Patient Monitoring in Recovery
318 Patient Monitoring Problem
319 Patient Positioning Problem
320 Problem with Appliance, Prostheses, Orthotic, Restorative, Splint, Device, etc.
321 Radiology or Imaging Error
322 Surgical or Other Foreign Body Retained
323 Wrong Diagnosis or Misdiagnosis (e.g., Original Diagnosis is Incorrect)
324 Wrong Dosage Administered
325 Wrong Dosage Dispensed
326 Wrong Dosage Ordered of Correct Medication
327 Wrong Medication Administered
328 Wrong Medication Dispensed
329 Wrong Medication Ordered
330 Wrong Body Part
331 Wrong Blood Type
332 Wrong Equipment
333 Wrong Patient
334 Wrong Procedure or Treatment

Unnecessary/Contraindicated Procedure
400 Contraindicated Procedure
401 Surgical or Procedural Clearance Contraindicated
402 Unnecessary Procedure
403 Unnecessary Test
404 Unnecessary Treatment

Communication/Supervision
500 Communication Problem Between Practitioners
501 Failure to Instruct or Communicate with Patient or Family
502 Failure to Report on Patient Condition
503 Failure to Respond to Patient
504 Failure to Supervise
505 Improper Supervision

Continuity of Care/Care Management
600 Failure/Delay in Admission to Hospital or Institution
601 Failure/Delay in Referral or Consultation
602 Premature Discharge from Institution
603 Altered, Misplaced or Prematurely Destroyed Records

Behavior/Legal
700 Abandonment
701 Assault and Battery
702 Breach of Contract or Warranty
703 Breach of Patient Confidentiality
704 Equipment Malfunction
705 Failure to Conform with Regulation, Statute, or Rule
706 Failure to Ensure Patient Safety (e.g., from Assault, Falls, Burns, Elopement, etc.)
707 Failure to Obtain Consent or Lack of Informed Consent
708 Failure to Protect a Third Party (e.g., Failure to Warn or Protect from Violence)
709 Failure to Test Equipment
710 False Imprisonment
711 Improper Conduct
712 Inadequate Utilization Review
713 Negligent Credentialing
714 Practitioner with Communicable Disease
715 Product Liability
716 Religious Issues
717 Sexual Misconduct
718 Third Party Claimant
719 Vicarious Liability
720 Wrongful Life/Birth

899 Cannot Be Determined from Available Records
999 Allegation – Not Otherwise Classified, Specify_____

* These codes were adapted from code lists developed by The Risk Management Foundation of the Harvard Medical Institutions and the Physician Insurers Association of America.